STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15C464			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE SUR COMPLETE	ED	
		15G464	B. WIN			10/26/20	12
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE OODLANE		
ARC OF	NORTHWEST INDI	ANA INC, THE			LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		OMPLETION DATE
W0000	REGUENTORT OR	ESC IDENTIFICATION)	+	1710			DITTE
			Wo	000			
		r a full recertification and					
		rvey. This visit included					
	the investigation #IN00118284.	of complaint					
	Complaint #IN00	0118284:					
	•	ED, Federal and state					
	deficiencies relat	ted to the allegations are					
	· ·	V104, W122, W149,					
	W153, W318 and	d W331.					
	Dates of survey:	October 15, 17, 18, 19					
	and 26, 2012						
	Facility number:						
	Provider number						
	AIM number: 10	00249370					
	Surveyor: Chris	tine Colon, Medical					
	Surveyor III/QM						
	The following de	eficiencies also reflect					
	1	accordance with 460 IAC					
	9.						
		npleted 11/2/12 by Ruth					
	Shackelford, Medica	ai Surveyor III.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000978

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G464	(X2) MULTIPLE CO A. BUILDING B. WING	00				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2414 WOODLANE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		

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Event ID: D4VZ11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPL	ETED
		15G464	B. WING			10/26/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
ADC 05		IANIA INIC. THE			OODLANE		
ARC OF	NORTHWEST INDI	ANA INC, THE		MEKKI	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	CROSS-REFERENCED TO THE APPROP			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0102	483.410						
	GOVERNING BC	DDY AND MANAGEMENT					
		ensure that specific					
	governing body a						
	requirements are						
	Based on record	review and interview for	W0102		See reference tag W122		11/27/2012
	1 of 3 sampled clients (client A), the						
	facility failed to	meet the Condition of					
	Participation: Go	overning Body. The					
	governing body	failed to exercise					
		on over the facility to					
		y implemented their					
		dures to prevent neglect					
		o ensure the health needs					
	of client A were	met. The governing					
	body failed for 5	of 5 clients living at the					
	group home (clie	ents A, B, C, D and E) to					
		ng direction over the					
	•	ete routine maintenance.					
	racinty to compr	ete routine mannenance.					
	Findings include	:					
	Please refer to	o W122. The governing					
		ercise general policy and					
		on over the facility in					
	_	ng the Condition of					
	•	ient Protections. The					
	governing body	neglected to implement					
	their neglect poli	icy and neglected to					
	protect 1 of 1 cli	ent (client A), from an					
	-	vn origin to her ear and					
	hospitalization o						
	nospitanzation o	1 0110111 / 1.					
	2 Planca rafor to	W219 The gaverning					
		W318. The governing					
	body failed to ex	ercise operating direction					

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Event ID: D4VZ11

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G464	B. WIN	G		10/26/2012	
NAME OF P	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
					OODLANE		
ARC OF	ARC OF NORTHWEST INDIANA INC, THE			MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	1	nursing services to meet					
		Participation: Health					
		The governing body failed					
	to provide adequ	_					
		treatment for 1 of 3					
	sampled clients	(client A).					
	2 10 6	W104 T1 :					
		o W104. The governing					
	1 -	xercise operating direction					
		to ensure their neglect					
	1 -	wed and neglected to					
	_	mpled clients (client A)					
		n injury which resulted in					
	_	The governing body					
		clients living at the group					
	,	B, C, D and E) to					
	_	ng direction over the					
	facility to compl	ete routine maintenance.					
	This federal tag	relates to complaint					
	#IN00118284.	retates to complaint					
	9-3-1(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
		15G464	A. BUILDING B. WING		10/26/2012		
NAME OF P	PROVIDER OR SUPPLIEI			ADDRESS, CITY, STATE, ZIP CODE			
			2414 WOODLANE				
	NORTHWEST IND		MERRI	LLVILLE, IN 46410			
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCT)	DATE		

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Event ID: D4VZ11

Facility ID: 000978

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
		15G464	1		·	10/26/2012	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL WATER INDI	IANIA INO TUE			OODLANE		
ARC OF NORTHWEST INDIANA INC, THE			MERKI	LLVILLE, IN 46410			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ection (X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0104		ody must exercise general					
	the facility.	nd operating direction over					
	Based on record	review and interview, the	W0	104	The Area Manager will have th	ne	11/28/2012
	governing body	failed to exercise			carpet professionally cleaned		
	operating direction	on over the facility to			within the next 30 days. The Area Manager will retrain DSPs on maintenance reporting within 30		
		ect policy was followed					
	_	protect 1 of 3 sampled			days (11/28/12). Maintenance		
	_	from an unknown injury			repair all damaged areas/items		
	` ′	n hospitalization. The			within the next 30 days. To		
		•			ensure future compliance the		
		failed for 5 of 5 clients			Property Director, Maintenance		
		up home (clients A, B, C,			crew, Area Manager, and staff	will	
	D and E) to exer	cise operating direction			monitor the condition of the		
	over the facility	to complete routine			carpet and home monthly and notify the appropriate persons	of	
	maintenance.				any changes. The Property	01	
	Findings include	:			Director, Maintenance crew, A Manager, and staff will monitor the home quarterly thereafter.		
1	1. Please refer to	o W149. The governing			12/5/12		
		tercise general policy and			As soon as the governing body was made aware, an investiga		
		on over the facility to			was made aware, an investigation was conducted and appropriate		
		olicy for Handling Cases			action was taken.		
	•	Abuse" for 1 of 3 sampled			All changes in condition with		
	_	•			regard to this individual are		
		who was hospitalized			reported immediately to the		
	for an unknown	mjury.			Service Coordinator and/or Nurse, documented and family	ı is	
	2. Please refer to	o W331. The governing			contacted immediately. In		
		of 3 sampled clients			addition, an administrator is		
	_	ensuring a nursing			notified of the issue. Action is taken in accordance with the		
					policy.		
		injury of unknown			policy.		
	_	was completed and by					
	not seeking time	ly medical attention.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLI	
		15G464	B. WIN	_		10/26/	2012
NAME OF	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL WATER IND	IANIA INIC. THE			OODLANE		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
TAG				TAG	BETTELLINETY		DATE
	1	eservation was conducted					
		ne on 10/15/12 from 6:00					
		A.M Upon entering					
		and E's home, the living					
	-	dark black stains					
	_	oom. The chandelier in					
	the back day roo	om nad 3 diown					
	lightbulbs.						
	An intervious wi	th Direct Support					
		SP) #1 was conducted on					
	,	A.M When asked how					
		ng had stains, DSP #1					
		uple of months." When					
	1	the light bulbs were					
	blown, sne indic	eated she did not know.					
	An interview wi	th the Service					
	Coordinator (SC	c) was conducted on					
	10/17/12 at 2:30	P.M When asked how					
	often maintenan	ce repair checks were					
	conducted at the	group home, the SC					
	stated, "Monthly	"." No further					
	documentation v	was available for review					
	to indicate when	the maintenance					
	concerns would	be addressed.					
	This federal tag	relates to complaint					
	#IN00118284.						
	9-3-1(a)						

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G464	(X2) MULTIPLE CO A. BUILDING B. WING	00				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2414 WOODLANE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		

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Event ID: D4VZ11

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLET		COMPLETED	
		15G464	B. WING		10/26/2012	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER						
ARC OF NORTHWEST INDIANA INC, THE			2414 WOODLANE MERRILLVILLE, IN 46410			
		<u> </u>		10-10-10		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
	†	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
TAG W0122	483.420 CLIENT PROTE The facility must protections requ Based on record Condition of Pa Protections was neglected to imp policy and negle sampled clients of unknown orig hospitalization of Findings includ Please refer to V to implement th neglected to pro (client A), from origin to her ear (client A).	ensure that specific client irements are met. If review and interview, the articipation: Client anot met as the facility plement their neglect ected to protect 1 of 3 (client A), from an injury gin to her ear and of client A.	W0122	Staff have been re-trained on requirements for reporting injure of unknown origin. An investigation will be initiated for injuries of unknown origin (11/28/12). To ensure future compliance, Service Coordinated Community Services Nursull review skin assessment sheets daily to monitor for any new injuries. 12/5/12Investigations for injurting of unknown origin will be conducted according to the policy. In this facility, steps to ensure future failure in the system identification of new injuries with injuries previously reported is being developed. This will enfuture compliance. The system failed in that the description of injury and the actual injury differed.	or all ator se / ies stem e for s. sure m	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G464		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/26/2012		
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE COODLANE LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W0149	The facility must of written policies are mistreatment, need Based on observer interview, for 1 of an injury of uninvolving 1 of 3. A), the facility no "Policy for Handland Abuse." Findings include A morning observation client home. An interview with Professional #1 (10/15/12 at 6:10 client A was at the aware why. A review of client conducted on 10. Review of client indicated: Nursing notation received a phone	evation was conducted at on 10/15/12 from 6:00 A.M During the entire at A was not at the group th Direct Support (DSP) was conducted on A.M DSP #1 indicated the hospital but was not	W0	149	Residential Program Dir will review reporting requirements Abuse, Neglect and exploitation of clients with the Service Coordinator and DSPs and document this review (11/28/1). To monitor for continued compliance, an Area Manager QMRP or Community Service Nurse will do bi-monthly observations. 12/5/12W149 SW104	2). -, s	11/28/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G464		A. BUILI	(X2) MULTIPLE CONSTRUCTION A. BUILDING OO			(X3) DATE SURVEY COMPLETED 10/26/2012	
		150404	B. WING			10/20/	2012
NAME OF I	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	IANA INC, THE			OODLANE LLVILLE, IN 46410		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
	noted that consu	mer woke up this					
	morning with blo	ood on her pillowcase and					
	that her right ear	had a scratch on it and					
	that the bleeding	had stop (sic). Staff					
	cleanse (sic) the	ear and applied triple					
	antibiotic ointme	ent. I ask (sic) staff					
		h was. I was told it was					
	across the top of	her ear not up and down					
	but across the ea	r. I ask (sic) staff at this					
	time can you pul	I the ear apart if you used					
		ds again is it a scratch or					
	-	of her ear. Staff told me					
	_	nn not be pulled apart. I					
		t looked like it could be					
	` ′	taff told me no that it was					
		rmed staff that they have					
		first aid care and to apply					
	• • •	0 minutes to the swollen					
	•	Call me or [Nurse #2]					
	_	orsens or any other					
		this problem." No					
	*	tation was noted in client					
		rd to indicate the					
		staff physically assessed					
		injury on 10/14/12.					
							
	A review of inve	estigation record #18218					
	and #18189 date	•					
		/19/12 at 2:35 P.M					
		cord indicated the					
	following:	Tota maioutou tiio					
	10110 111115.						
	Incident report d	ated 10/14/12: "[Client					
	•	dried blood on her arm					
	11 WORE up With	arioa orooa on nor urm					

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	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	COMPLETED
15G464 B. WING	10/26/2012
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
2414 WOODLANE	
ARC OF NORTHWEST INDIANA INC, THE MERRILLVILLE, IN 46410	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION OF CORRECTION OF CORRECTION SHOULD BE	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
and pillow. Didn't know where blood	DAIL
came from until I (DSP #13) examined	
her body and discovered there was blood in her hair also and was coming from her	
earCleaned affected area and put	
·	
ointment on it and ice. Checked through	
out the dayWhich person (s) was this incident/accident referred to?Nurse, by	
phoneParties notified: [Residential	
Facility and Management Director name],	
10/14/12 at 2:00 P.M., [Behavior Health	
Director], 10/14/12, 2:00 P.M Part B	
completed by: [Service Coordinator	
name], 10/15/12 11:30 A.M" The report	
did not indicate the facility's administrator	
was immediately notified of client A's	
injury of unknown origin.	
Bureau of Developmental Disabilities	
Services (BDDS) report dated 10/14/12	
indicated: "Received a call at 1:35 P.M.	
on 10/14/12 from [client A's guardian]	
(Service Coordinator). She stated that her	
niece had come to pick [client A] up and	
noticed she was bleeding. They (client	
A's niece and DSP #13) traced the blood	
to her ear where there is approximately a	
1 inch curved cut. At this time, it is	
unclear how the injury occurredService	
Coordinator visited the group home and	
directed staff to take [client A] to the ER	
(Emergency Room] for evaluation of the	
cut. She remains in the hospital at this	
time and is set for surgery to remove a	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G464			LDING	NSTRUCTION 00	(X3) DATE COMPI 10/26	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2414 WOODLANE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE	
	blood clot from I 10/16/12An in of injury has bee (sic) been susper "Date 10/15/12 investigation: [Oals A's niece] stated aunt's (client A) on Sunday to tak When she entere was sitting in a ctrying to tie her swent over to assis shoe and noticed A]'s pink shirt. I middle of her for upper arm (near that at first becaumaybe it was chemical propers and noticed and the state of	ner ear at noon tomorrow vestigation into the cause in initiated and staff has inded at this time." Phone Interview for Client A's niece]: "[Client that she went to her home around 12:15 P.M. is her some snack foods. In the home, [client A] thair in the t.v. room shoe. [Client A's niece] ist [client A] with the in a dark stain on [client A] the stain went from the rearm to the middle of her the muscle). She stated use it was dark brown that occolate, since she has			CROSS-REFERENCED TO THE APPROP			
	she has had food closer look she the blood. [Client A #13] if she knew [DSP #13] put of that it looked lik niece] lifted her blood had come anything. She to should take her i both took her shi #13] stated she v	all over her. Taking a then thought it might be the distribution of the stain was and the her gloves and stated to blood. [Client A's shirt to see where the from and did not see the from the bathroom. They art off of her and [DSP was going to go look in the bed. [Client A's						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G464			LDING	NSTRUCTION 00	(X3) DATE COMPI 10/26	LETED	
	PROVIDER OR SUPPLIER		p. why	STREET A	ODDLANE LVILLE, IN 46410		
	NORTHWEST INDI			<u> </u>	LVILLE, IIN 404 IU		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
		d 'I know where it is					
	_	om the ear.'Blood in					
		came back with the					
		stated that there was					
	_	e. [DSP #13] then					
		shirt and pillow case and					
	l -	where. [Client A's niece]					
		o her room to get her a					
		ent A's niece] noticed					
	-	ow that had soaked					
		w case. This is when she					
	_ ^	Both [DSP #13] and					
	•	walked [client A] back					
	-	e t.v. room where [DSP					
		nt on her ear. [Client A's					
		t the stain was enormous					
		lood was still coming out.					
		#13] if someone was					
	_	[DSP #13] responded					
		d see her because it was					
	Sunday, but she	will go to workshop and					
	they will look at	her. [DSP #13] and					
	[client A's niece]	went to the bedroom to					
	see if she could l	have hit something/fell					
	out of the bed. (Could not see anything					
	that could have o	caused the injury. [DSP					
	#13] stated she v	vas with her until 10:00					
	P.M. the night be	efore and had not noticed					
	anything. [Clien	at A's niece] asked her					
		noticed such a large stain					
	and [DSP #13] s	tated I did not notice.					
	[Client A's niece	e] went outside to call her					
	_	er aunt that she thought					
	[client A] should	be seen by a doctor.					

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Event ID: D4VZ11

Facility ID: 000978

If continuation sheet

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G464	A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI 10/26	LETED
		130404	B. WIN			10/20	72012
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE OODLANE		
ARC OF	NORTHWEST IND	IANA INC, THE			LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		nouse and was told that it					
		[client A] would be seen					
		Aunt called [SC] and					
	_	nt A's niece] back to tell					
		to the house because					
	_	C] that she had been					
		ry. [SC] showed up at					
		ld [DSP #13] to take her					
		y room. [DSP #13]					
		n the one who has to take					
		I do not care who takes					
	her, but someone	e needs to. [DSP #13] got					
	off the van at the	e hospital and walked					
	away from [clien	nt A] because it was					
	raining and she	lid not want to get wetit					
	was quite a dista	nce between [client A]					
	and [DSP #13].	[Client A's niece] had to					
	assist [client A]	up the curb because					
	[client A] is scar	ed to walk up. While					
	registering [clien	nt A] they asked when her					
	birthday was and	d [client A's niece] did not					
	know. They ask	ed who her doctor was,					
	[client A's niece]	did not know and [DSP]					
	#13] stated it wa	s a long time since she					
	had to take anyo	ne to the hospital 'I don't					
	know the proced	ure and I did not bring					
	anything with m	e.' [Client A's niece]					
		or the information. [DSP					
		extra underwear and					
		erself. Had to tape a					
		herI (investigator #1)					
		s niece] back on 10/16/12					
		P #14], the other staff. I					
	_	[DSP #14] was when she					
							<u> </u>

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Event ID: D4VZ11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G464		(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE S COMPL 10/26/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2414 WOODLANE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	stated that neither was at the house see [DSP #13] ca phone and heard noticed any injurt after the call [DS door. [Client A's thought it was stated the house because that she has been weekend only [December 10/15/12 [Client A's sister A's sister], [client A's sister], [client that [client A] we due to a blood of going through the were also going she may have a constant of the stated to aunt that by a blow/hit to "Date 10/16/12 #13]: I last work Sunday, October injury when the located on the to gets up on her ow A] to sit for a whom the stated to a sit for a whom the stated to sit for	use. [Client A's niece] or [DSP #14] or her car . [Client A's niece] did all [DSP #14] on the her ask if she had ry to [client A]. Not long SP #14] walked in the s niece] stated that she range that [DSP #13] was huse the last 3-4 weeks a to see [client A] on the DSP #14] has been there. of been 2 staff at the SP #14] has been there. of been 2 staff at the Phone Interview: Is I spoke with [Client at A]'s aunt. She stated as going to have surgery of on her ear. They were the back of the ear. They to try to repair the ear and couple of stitches. Doctor at the injury was caused the head/ear." Main Center: [DSP and with [client A] on 14, 2012. I noticed the niece arrived. It was p upper right ear. She wn. It's normal for [client nile after getting up unless handed (sic) pop. When						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G464	LDING	NSTRUCTION 00	(X3) DATE COMPI 10/26	LETED
	PROVIDER OR SUPPLIER		STREET A	DDRESS, CITY, STATE, ZIP CODE OODLANE LVILLE, IN 46410	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	her to go to the hamy response. We was bad enough that's when we pershe got there we check her body are cut was at. I call said to keep areasice and they will Monday morning the pillow case we it on her sleeve. It is because that's the room. At first cut I didn't think the hospital but we light it looked printhe (sic) unless to her which is not her self We prove we got in van to ER room for bouther registered. So back got the eare came in and said look at it so he we and put her in a self-own for cut on to whomever on demanding her to	d up she said she wanted tospital. I can't remember then [SC] came she said it to go to the hospital and roceeded to go. When took her in bathroom to and discovered where the led the nurse first and she clean with ointment and get her to the doctor on g. I noticed the blood on when the niece discovered The reason I put 10 A.M. the time she came out of st when I seen (sic) the it was that bad to go to when I seen (sic) it in the letty bad. No abuse seen so other client tries to get of often or when she hits beeded to the hospital. In go to hospital and sat in the seeded to the hospital and sat in the cleaned up. The doctor he wanted to get a closer was going to numb her ear froom. He said that it to hold but he wasn't the first to the nurse as a deep the ear When speaking the phone, they were ongo to the hospital and I the nurse and see what				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G464	B. WIN			10/26/	2012
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
450.05	NODEL WATER TIME				OODLANE		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·		TAG	Dirichi.e.i,		DATE
	· ·	will go from there. She					
	was saying she saw the pictures and wanted her to go now but I had to follow						
	_	eI (investigator #1)					
		SP #14] was during this					
	_	#13) stated that she was					
	`	he was in the basement. I					
		one was she, out of the					
		pasement. She stated					
		ting lunch, but was only					
		sShe was out of the					
	house."						
	110 0.50						
	"Date 10/16/12	Main: [Area Manager]:					
		s are double staffed at all					
		ring the night shift. Any					
	•	the group home during					
		nt should be with them."					
	"Date 10/16/12	[Service Coordinator]: I					
	received a call S	unday at 1:35 P.M. from					
	[client A's Sister	#2] stating that her niece					
	had visited [clien	nt A] and noticed she had					
	dried blood on h	er sleeve. She stated staff					
	and [client A's n	iece] took [client A] into					
	the bathroom to	do a body check. They					
	didn't find any in	njury. [Client A's niece]					
	looked in [client	A]'s bedroom and					
	noticed blood or	her pillow. She then					
	_	A]'s head finding blood in					
		nt on her right ear. I					
		home speaking to [DSP					
	_	ted her to write an					
	incident report to	o which she said, 'I guess					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G464		LDING	00	COMPL 10/26/	
		100404	B. WIN			10/20/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			OODLANE LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	· · · · · · · · · · · · · · · · · · ·	, huh?' I asked the					
		cut. [DSP #13] said she'd					
		name] who directed her					
		and apply antibiotic					
		t the wound looked much					
		ed blood but once it was					
		l better. I told her I was					
		en I arrived [client A]					
	_	r chair. I could see the					
		from entrance. I put on					
		ed at [client A]'s ear					
	_	ut through her ear. It was					
	_	then told both staff,					
		to take her to the ER.' To					
	this [DSP #13 sa	id 'So I guess it's gotta be					
	me that does that	t too. If it's like that, its					
	like that, oh o.k	' I said, 'It doesn't matter					
	who takes her, so	omeone needs to grab the					
	emergency folde	er and take her. Her niece					
	will follow you.'	While [DSP #13] got					
	[client A] ready	to go, her niece and I					
	went to the bedro	oom to talk. I noticed					
	•	on the bed. her niece					
	said 'I wanted to	take pictures of the					
	pillow and shirt,	but the first thing [DSP					
	#13] did was thre	ow them in the washer.'					
	We noticed a har	nger (wire) on the bed. I					
	cleaned it to che	ck for blood but there					
	was none. I chec	cked the room for sharp					
	objects or corner	s but found none. The					
	niece said she fe	lt [DSP #13] had an					
	attitude because	when [client A's sister					
	#2] asked that [c	lient A] be taken to get					
	medical attention	n, that [DSP #13] said 'Oh					
	l						l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G464	B. WIN			10/26/2012
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	
ADC OF	NORTHWEST IND	IANIA INIC. THE			OODLANE LLVILLE, IN 46410	
				<u> </u>	_LVILLE, IIN 404 IU	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
1110		c) do that, it's the		0		J.II.
	`	I looked at the incident				
		ed for 10 A.M. as if staff				
	_	before niece arrived, but				
		ne to be done at around 2				
		me there were no other				
		No one had attacked				
		ey had no idea what had				
		nt A's niece] stated her				
	* * *	ith the bloody pillow.				
		[client A] was in different				
	clothes and pillo	_				
	cionies and pino	www.missing.				
	"Date 10/16/12	.Investigator office				
		ceived a phone call from				
		0/14/12 at 1:28 P.M				
		that she noted that				
	consumer woke	up this morning with				
		n and pillowcase and that				
		bleeding from what what				
	_	tch. I ask (sic) staff to				
		s client (sic) she told me				
		ill hit herself a lot of				
	times. She then	told me that this				
	consumer's fami	ly member was at the				
	house and wante	d her to go to the				
	emergency room	. Staff told family that				
	she had to call th	ne nurse. DSP told me				
	that they tried to	call [nurse #2] (this				
	<u> </u>	there was no answer. So				
	I received a call	on the emergency. DSP				
		ne that it was a scratch on				
	[client A]'s right	ear and that she cleanse				
	(sic) the area (sic	e) applied triple antibiotic				

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G464		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 10/26/2012				
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2414 WOODLANE MERRILLVILLE, IN 46410						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE				
	ointment and the bleeding had stop (sic). I questioned the DSP staff several times about this matter asking was it a scratch or a laceration. DSP staff continued in saying it was a scratch on her ear. I ask (sic) what part of the ear (sic) she told me it was on top of the ear and that the scratch was not vertical but it was horizontal. I then ask (sic) this DSP staff if she could take both of her hands and pull the ear apart where the scratch was noted to be she replied no that it was just a scratch and that the ear was swollen. I informed her a scratch to the ear was not an emergency (sic) to apply an ice pack to the swollen part of the ear for 20 minutes. Staff told me that consumer will not let her hold ice to her ear. I told her to try and if the problem gets worse or any other complaints to please call me back or call her nurse [nurse #2]." "Date 10/16/12: Nurse office[Nurse #2]: I spoke with family of [client A] at approximately 1:00 P.M. on 10/16/12. She (the sister) stated that during surgery, they cleaned out infection in her ear. She stated that she received 7 stitches. I asked her if the doctor knew how the laceration occurred and she stated blunt force trauma." "Conclusion: Injury of unknown "Conclusion: Injury of unknown "Conclusion: Injury of unknown							
	origin-Substantiated. Staff do not know							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G464	B. WIN	G		10/26/	2012
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					OODLANE		
ARC OF	NORTHWEST INDI	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	how injuries occ	•					
		leglect, falsification of					
		failure to follow agency					
		dureBoth [staff #13 and					
	_	for neglect, Falsification					
		n, Failure to follow					
	agency policy an	nd procedure."					
		nt A's hospital medical					
		ucted on 10/26/12 at 3:20					
		f the medical record					
	indicated:						
		(ENT) physician					
	notation dated 10	0/15/12: "Diagnosis:					
	Laceration to rig	ht ear of undetermined					
	duration and orig	gin-hematoma of right					
	ear, possible trau	ımatic origin and bilateral					
	cerum impaction	Ear: Right. There is					
	right ear pain the	e almost healed laceration					
	which is horizon	tal in nature. There is a					
	hematoma under	neath this. The cartilage					
		to be slightly distorted on					
	the right side. T						
	sediment in right	•					
	_	tion no obvious trauma."					
		The second value of the se					
	Primary Care Ph	ysician (PCP) notation					
	-	"laceration: Right					
		of neglectDrain					
	`	r laceration and remove					
	impacted cerume						
	impacica cerum	onaciany.					
	A review of the	facility's "Policy for					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G464		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/26/2012		
	PROVIDER OR SUPPLIER			2414 W	OODLANE		
	NORTHWEST IND			<u> </u>	LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
		of Neglect and Abuse"		0			D.II.E
	_	was conducted on					
		P.M Review of the					
		indicated: "In order to					
		ral welfare of the clients,					
	^ ~	t Indiana], Inc. has in					
	_	ring policy with regard to					
		r exploitation of clients by					
		All allegations of abuse,					
	1 -	tion or exploitation will					
	be investigated p	*					
		· is defined as knowingly					
	1	in a situation that poses a					
		health and well-being.					
		le but are not limited to					
	_	nt of food, clothing,					
		al care; not providing					
		al care, leaving clients					
		cInternal investigation					
	refers to a situati	_					
		ressed within the					
	department (pos						
	includean inju	•					
	1	a staff person is involved,					
		vitnesses an incident of					
	· · · · · · · · · · · · · · · · · · ·	neglect or injury to a					
	_	person(s) observing or					
		e aware of the incident					
		ly: a. secure the safety of					
	the individual(s)	•					
	` ′	begin the investigation					
		listc. verbally inform					
	l ~	te supervisor of the					
		nt and/or individual					
							<u> </u>

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Event ID: D4VZ11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G464		A. BUIL	DING	NSTRUCTION 00	(X3) DATE COMPI 10/26	LETED	
		130404	B. WING				72012
NAME OF I	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC. THE			OODLANE LLVILLE, IN 46410		
				l	LEVILLE, IIV 40410		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	ION D BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPRI DEFICIENCY)		DATE
	responsible for the	· · · · · · · · · · · · · · · · · · ·		_			
		omit an incident report					
		eded and necessary					
	_	is/her supervisore.					
		assessment if there is					
	injury noted or s						
	injury noted or s	uspected.					
	An interview wit	th Licensed Practical					
		was conducted on					
	` ′	P.M When asked if she					
		1 10/14/12 in regards to					
		LPN #2 stated "Yes, the					
		tempted to contact the					
	-	gned nurse, but she did					
	• •	hone, so the staff called					
	_	e and reached me."					
		ne injury was considered					
		nown origin, the LPN					
		hen asked if nursing staff					
		uries of unknown origin,					
		I don't know what the					
		" When asked if she or					
		e went to the group home					
		ssessed client A's injury					
		in, the LPN stated, "No, I					
	_	check it on Monday					
		it was a scratch." When					
		cted DSP #13 not to take					
		nergency room after the					
		requested she be taken,					
	*	Yes, I told her to do first					
	aid care and not						
		because it was a scratch,					
		not require emergency					
	and scrattines do	not require emergency					

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	OF CORRECTION OF CORRECTION 15G464	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	COM	ie survey ipleted 26/2012
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	2414 W	DDRESS, CITY, STATE, ZIP CO OODLANE LLVILLE, IN 46410	DDE .	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	care." An interview with LPN #2 was conducted				
	on 10/26/12 at 4:15 P.M When LPN #2, who is the assigned group home nurse, was asked what client A's Physician noted the injury of unknown origin as being caused from, she stated "Blunt force trauma."				
	An interview with the Service Coordinator (SC) was conducted on 10/26/12 at 4:00 P.M The SC indicated there should have been two staff at the group home on 10/14/12. The SC indicated nursing staff should have gone to the group home to physically assess client A's injury and further indicated client A should have been taken to the emergency room when the guardian requested client A be transported for medical attention. When asked if she went to the hospital with client A, the SC stated "No."				
	This federal tag relates to complaint #IN00118284. 9-3-2(a)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: D4VZ11

Facility ID: 000978

If continuation sheet

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PRINTED: 12/11/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G464	(X2) MULTIPLE CO A. BUILDING B. WING	00		
	PROVIDER OR SUPPLIER		2414 W	ADDRESS, CITY, STATE, ZIP (OODLANE LLVILLE, IN 46410	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: D4VZ11

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AND PLAN OF CORRECTION DIENTIFICATION NUMBER: 15G464 10/26/2012	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE REQUATORY OR LOE DEFICIENCIES (ICACH DEFICIENCY MUST BE PRECEDED BY FULL TAG SUMMARY STATEMENT OF DEFICIENCIES (ICACH DEFICIENCY MUST BE PRECEDED BY FULL REQUATORY OR LSC DIBUTIPTING INFORMATION) W0153 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, the facility failed for 1 of 1 incident of injury of unknown origin involving 1 of 3 sampled clients (client A), to report the injury of unknown injury immediately to the administrator in accordance with state law. Findings include: A review of investigation record #18218 and #18189 dated 10/15/12 was conducted on 10/19/12 at 2:35 P.M Review of the record indicated the following: Incident report dated 10/14/12: "[Client A] woke up with dried blood on her arm and pillow. Didn't know where blood INCOMPLETION MERCILONS MICHAEL (IN 46410 PREFIX MERRILLVILLE, IN 46410 DATE ***CACH DEFICIENCE OF COMPLETION TO COMPLETION	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	DING	00	COMPLETED	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE (X4) ID PREERIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) W0153 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown origin involving 1 of 3 sampled clients (client A), to report the injury of unknown origin involving 1 of 3 sampled clients (client A), to report the injury of unknown injury immediately to the administrator in accordance with state law. Findings include: A review of investigation record #18218 and #18189 dated 10/15/12 was conducted on 10/19/12 at 2:35 P.M Review of the record indicated the following: Incident report dated 10/14/12: "[Client A] woke up with dried blood on her arm and pillow. Didn't know where blood			15G464	1			10/26/	2012
ARC OF NORTHWEST INDIANA INC, THE CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) TAG PREFIX TAG				1		ADDRESS, CITY, STATE, ZIP CODE		
ARC OF NORTHWEST INDIANA INC, THE (X4) ID REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W0153 W0153 W0153 W0153 W0154 W0155 W0155 W0155 W0155 W0156 W0156 W0157 W0157 W0157 W0157 W0157 W0157 W0158 W0158 W0158 W0158 W0158 W0158 W0159 Service Coordinator contacted administrator in regards to this injury of unknown rigin involving I of 3 sampled clients (client A), to report the injury of unknown rigin involving I of 3 sampled clients (client A), to report the injury of unknown injury immediately to the administrator in accordance with state law. Findings include: A review of investigation record #18218 and #18189 dated 10/15/12 was conducted on 10/19/12 at 2:35 P.M Review of the record indicated the following: Incident report dated 10/14/12: "[Client A] woke up with dried blood on her arm and pillow. Didn't know where blood	NAME OF P	ROVIDER OR SUPPLIER	t .					
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROBLEMENTY PREFIX TAG PROB	ARC OF	NORTHWEST INDI	IANA INC, THE					
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) W0153 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, the facility failed for 1 of 1 incident of injury of unknown origin involving 1 of 3 sampled clients (client A), to report the injury of unknown injury immediately to the administrator in accordance with state law. Findings include: Findings include: A review of investigation record #18218 and #18189 dated 10/15/12 was conducted on 10/19/12 at 2:35 P.M Review of the record indicated the following: Incident report dated 10/14/12: "[Client A] woke up with dried blood on her arm and pillow. Didn't know where blood TAG CROSS-REFERRECED TO ITHE APPROPRIATE DDATE DATE PDEMILION TO PREMINENCY TO THE APPROPRIATE DEMILION TO THE APPROPRIES 11/28/2012 11/28/2012 11/28/2012 Service Coordinator contacted administrator in regards to this injury. This was not documented on the incident report. 11/28/12). To ensure further administrator notification on incident report. 12/25/12 W153 See W104 In addition, the administrator contacted								
W0153 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, the facility failed for 1 of 1 incident of injury of unknown origin involving 1 of 3 sampled clients (client A), to report the injury of unknown injury immediately to the administrator in accordance with state law. Findings include: A review of investigation record #18218 and #18189 dated 10/15/12 was conducted on 10/19/12 at 2:35 P.M Review of the record indicated the following: Incident report dated 10/14/12: "[Client A] woke up with dried blood on her arm and pillow. Didn't know where blood Text and a service Coordinator contacted administrator notification contacted will injuries of unknown origin to the administrator will report all injuries of unknown origin to the administrator will document administrator notification on incident report. 12/5/12 W153 See W104 In addition, the administrator contacted will initial the incident/accident report.		`				CROSS-REFERENCED TO THE APPROPRIAT	TE	
STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, the facility failed for 1 of 1 incident of injury of unknown origin involving 1 of 3 sampled clients (client A), to report the injury of unknown injury immediately to the administrator in accordance with state law. Findings include: A review of investigation record #18218 and #18189 dated 10/15/12 was conducted on 10/19/12 at 2:35 P.M Review of the record indicated the following: Incident report dated 10/14/12: "[Client A] woke up with dried blood on her arm and pillow. Didn't know where blood Service Coordinator contacted administrator in regards to this injury. This was not documented on the incident report. Service Coordinator will report all injuries of unknown origin to the administrator will document administrator notification on incident report. 12/5/12 W153 See W104 In addition, the administrator contacted administrator in regards to this injury. This was not documented on the incident report. Service Coordinator will inverse of unknown origin to the administrator will document administrator molification on incident report. 12/5/12 W153 See W104 In addition, the administrator contacted will initial the incident/accident report.			LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
discovered there was blood in her hair also and was coming from her earCleaned affected area and put ointment on it and ice. Checked through out the dayWhich person (s) was this incident/accident referred to?Nurse, by phoneParties notified: [Residential		483.420(d)(2) STAFF TREATMI The facility must of mistreatment, rinjuries of unknow immediately to the officials in accord through establish. Based on record facility failed for of unknown orig sampled clients (injury of unknow the administrator law. Findings include A review of inveated and #18189 date conducted on 10. Review of the refollowing: Incident report day woke up with and pillow. Diducted came from until discovered there also and was context. Cleaned afficient out the dayWhincident/accident	ENT OF CLIENTS ensure that all allegations neglect or abuse, as well as vn source, are reported e administrator or to other ance with State law ed procedures. review and interview, the r 1 of 1 incident of injury in involving 1 of 3 (client A), to report the vn injury immediately to r in accordance with state estigation record #18218 d 10/15/12 was /19/12 at 2:35 P.M cord indicated the ated 10/14/12: "[Client a dried blood on her arm of t know where blood I examined her body and was blood in her hair ming from her ected area and put and ice. Checked through ich person (s) was this t referred to?Nurse, by	W0		Service Coordinator contacted administrator in regards to this injury. This was not document on the incident report. Service Coordinator will report all injuri of unknown origin to the administrator within 24 hours (11/28/12). To ensure future compliance, Service Coordinat will document administrator notification on incident report. 12/5/12 W153 See W104 In addition, the administrator contacted will initial the	ed ies	

FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: 000978

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G464	(X2) MULTIPLE CO A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 10/26/2012	
	ROVIDER OR SUPPLIER		2414 W	ADDRESS, CITY, STATE, ZIP CO OODLANE LLVILLE, IN 46410	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION	1
	10/14/12 at 2:00 Director], 10/14/completed by: [name], 10/15/12 did not indicate was immediately injury of unknow. An interview was Service Coordin administrative of P.M The SC in not immediately home staff to the stated "Incidents immediately to the states."	nagement Director name], P.M., [Behavior Health /12, 2:00 P.M Part B Service Coordinator 11:30 A.M" The report the facility's administrator y notified of client A's wn origin. Is conducted with the ator (SC) at the facility's effice on 10/19/12 at 4:00 edicated the incident was reported by the group e administrator. The SC are to be reported the administrator." I relates to complaint				

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Event ID: D4VZ11

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED	
		15G464	B. WIN			10/26/2	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				OODLANE		
ADC OF	NORTHWEST INDI	ANA INC. THE			LLVILLE, IN 46410		
	NORTHWEST INDI	ANA INO, TIL		IVILIXIXI	LLVILLE, IIV 404 10		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W0192	483.430(e)(2) STAFF TRAINING For employees what training must focus competencies dirented in needs. Based on observed administration (ed demonstrating sk administer medical findings included in the group home of the group home o	G PROGRAM ho work with clients, us on skills and ected toward clients' health ation, record review and cility failed for 1 of 3 during medication client C) by staff not cilis and competency to cations as prescribed. Evation was conducted at the conducted at th	W0	TAG	The Community Service Nurse will re-train DSP's on how to follow medication orders and record results on Medication Administration Record in accordance with physician's or (11/28/12). To ensure future compliance the Community Services Nurse will visit group home at least bi-monthly for the months and at least quarterly thereafter. 12/5/12 W192 Nurse will conduct random checks on medication administration at least two per week for one month, one per week for two months and mon thereafter.	rder	11/28/2012
	An interview wit	th the nurse was					

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PRINTED: 12/11/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 15G464	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/26/2012			
ARC OF	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2414 WOODLANE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPI	K5) LETION TE		
	conducted on 10/26/12 at 11:40 A.M The nurse indicated staff should administer all medications as prescribed. The nurse further indicated staff should follow directions on medication labels on medication packets. 9-3-3(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		15G464	B. WIN			10/26/	2012
NAME OF B	DOWNER OF CHIRD IED		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			2414 W	OODLANE		
ARC OF	NORTHWEST INDI	IANA INC, THE		MERRI	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG W0249	483.440(d)(1)	LSC IDENTIFYING INFORMATION)	-	TAG	DLI ICILACI)		DATE
VVU249	PROGRAM IMPL	EMENTATION					
		terdisciplinary team has					
	formulated a clier	nt's individual program plan,					
	each client must receive a continuous active treatment program consisting of needed						
		n consisting of needed services in sufficient					
		uency to support the					
		ne objectives identified in					
	the individual program plan.						
	Based on observ	ation, record review, and	W0	249	DSPs have been retrained on		11/28/2012
	interview, the fac	cility failed to implement			implementing goals and	4la a	
	written objective	es during times of			objectives in accordance with ISP (11/28/12). To ensure futu		
	opportunity for 2	2 of 3 sampled clients and			compliance, the Service		
	1 additional clier	nts (clients B, C and E).			Coordinator will observe		
	Findings include	:			implementation of the program objectives at least monthly for three months and periodically thereafter.		
	A morning obser	rvation was conducted at			12/5/12		
	the group home	on 10/15/12 from 6:00			Service Coordinator will condu	ıct	
	A.M. until 7:40	A.M During the entire			random visits to the home to		
	observation perio	od clients B, C and E did			observe and instruct staff, who necessary, on implementation		
	not communicate	e in their home. At 6:25			objectives toward achievemen		
	A.M., Direct Sur	oport Professional (DSP)			those objectives at least two p		
	#1 passed client	•			week for one month, one per		
	•	ent E did not point to			week for two months and mon thereafter.	เทเง	
		nedication and face for			morealter.		
		m. At 6:40 A.M., DSP					
		client C's prescribed					
		ient C did not point to her					
	medications befo	-					
		t 7:18 A.M., DSP #1					
		ent B's prescribed					
		ient B did not learn					
		at her medications. Client					
		communication (picture)					
		- (picture)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	ETED
		15G464	B. WIN			10/26/2	2012
NAME OF B			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	C		2414 W	OODLANE		
	NORTHWEST IND	IANA INC, THE		MERRII	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)	1	DATE
		t learn 5 new words and					
	_	nt C did not learn to					
	identify 5 pictures and signs from her communication book. Client E did not						
	learn to use a co	mmunication aide.					
	An evening observation was conducted at the group home on 10/15/12 from 5:00 P.M. until 7:00 P.M During the entire						
	observation peri	od clients B, C and E did					
	not communicate in their home. Client B						
	did not use a communication (picture)						
		t learn 5 new words and					
		nt C did not learn to					
	_	es and signs from her					
		book. Client E did not					
	learn to use a co	mmunication aide.					
	A review of clie	nt B's record was					
	conducted at the	facility's administrative					
	office on 10/17/	12 at 11:50 A.M					
	Review of client	B's Individual Support					
	Plan (ISP) dated	6/8/12 indicated the					
	following: "Wil						
	_	(picture) bookwill learn					
		d then sign (stop, go,					
		will continue to learn					
		ut her medications."					
	miomiunon audi	at her modications.					
	A review of clie	nt C's record was					
	conducted at the	facility's administrative					
		12 at 12:20 P.M Review					
		ividual Support Plan (ISP)					
		dicated the following:					
	uaicu 0/20/12 III	dicated the following.					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G464	LDING	NSTRUCTION 00	(X3) DATE COMPI 10/26	LETED
	PROVIDER OR SUPPLIER		 2414 W	DDRESS, CITY, STATE, ZIP CODE DODLANE LVILLE, IN 46410	•	
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE
	from her commu continue to learn medications befo administered."	ore they are				
	office on 10/17/1 of client E's Indi dated 6/22/12 ind "Will learn to us	facility's administrative 12 at 12:50 P.M Review vidual Support Plan (ISP) dicated the following: e a communication to point to mouth for oral				
	interviewed on 1 The SC stated cl implemented "du opportunity." T	he SC further indicated e implemented each				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:		00	COMPLETED		
	15G464	A. BUILDING		10/26/2012		
		B. WING				
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE			
	NORTHWEST INDIANA INC. THE	2414 WOODLANE				
ARC OF	NORTHWEST INDIANA INC, THE	MERRI	LLVILLE, IN 46410			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID PROVIDERS PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
W0318	483.460					
	HEALTH CARE SERVICES					
	The facility must ensure that specific health					
	care services requirements are met.	1110210		11/00/0010		
		W0318	Please refer to tag W331	11/28/2012		
	Based on record review and interview, the					
	Condition of Participation, Health Care					
	Services, is not met as the facility failed					
	to provide adequate nursing services for 1					
	of 3 sampled clients (client A).					
	or 5 sampled elicitis (eliciti 11).					
	Findings include:					
	Please refer to W331. The facility failed					
	for 1 of 3 sampled clients (client A) by					
	not ensuring a nursing assessment of an					
	injury of unknown origin to her ear was					
	1 , ,					
	completed and by not seeking timely					
	medical attention.					
	This federal tag relates to complaint					
	#IN00118284.					
	9-3-6(a)					
			1			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED	
		15G464	A. BUII B. WIN			10/26/	2012
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	t .			OODLANE		
ARC OF	NORTHWEST INDI	IANA INC, THE			LLVILLE, IN 46410		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A review of client A's record did not returned for a he years as recomm A review of client A's record did not returned for a he years as recomm A review of client as record did not returned for a he years as recomm A review of client as record did not returned for a he years as recomm A review of client as record did not returned for a he years as recomm A review of client record was conditionally as record did not returned for a he years as recomm A review of client record was conditionally as record was conditionally as record did not returned for a he years as recomm. A review of client record was conditionally as record was con	eVICES provide or obtain annual tions of each client that at a s an evaluation of vision review and interview, the r 1 of 3 sampled clients vide a hearing sment as recommended 	W0	TAG	Client A has had a hearing assessment scheduled (11/28/12). To ensure future compliance, Service Coordinator and Nurse will monitor appointments to ensure that clients attend all scheduled appointments.		
	(client A) to prove valuation/assess by the physician Findings include A review of client conducted on 10 Client A's record hearing evaluation indicated a return A's record did not returned for a heaview of client record was conducted. A review of client record was conducted by a review of client record was conducted. Doctors notation Right. There is a healed laceration nature. There is this. The cartillagent in the c	wide a hearing sment as recommended. The contain a second was a second with			(11/28/12). To ensure future compliance, Service Coordinator and Nurse will monitor appointments to ensure that clients attend all	e	

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Facility ID: 000978

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	of correction identification number: 15G464	(X2) MULTIPLE CC A. BUILDING B. WING	00		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	2414 W	ADDRESS, CITY, STATE, ZIP OODLANE LLVILLE, IN 46410	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	canalLeft: Sediment impaction no obvious trauma."				
	The Licensed Practical Nurse (LPN) was interviewed on 10/26/12 at 11:40 A.M The LPN indicated there was no evidence client A returned as recommended by the physician. 9-3-6(a)				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) I			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLETED	
		15G464	A. BUII B. WIN			10/26/2	012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L					
ABC OF	NORTHWEST INDI	IANIA INC. THE			/OODLANE LLVILLE, IN 46410		
ARC OF	NORTHWEST INDI	ANA INC, THE		MEKKI	LLVILLE, IN 404 IU		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0331	483.460(c)						
	NURSING SERV						
		provide clients with nursing dance with their needs.					
			W0	221	Compression Complete Number video		11/28/2012
		ation, record review and	WO	331	Community Services Nurse wi assess all injuries of unknown	I	11/28/2012
		of 3 sampled clients			origin if there is any question t		
		cility failed to provide			injury needs medical attention		
	nursing services	for the client's unknown			A Nurse is not able to assess		
	injury.				injury in person, staff will be		
					directed to Urgent Care or the		
	Findings include	•			local Emergency Room. Staff		
	1 1114111185 1114144	•			have been re-trained on prope		
	A morning abou	rvation was conducted at			describing injuries to nursing staff		
					(11/28/12). To ensure future compliance, Nurses will contin		
	• •	on 10/15/12 from 6:00			to work with staff on determini		
		A.M During the entire			severity of injuries. 12/5/12Nu	-	
	observation clier	nt A was not at the group			is to evaluate the issue/injury		
	home.				based upon the information given	ven	
					to them. In this case, the		
	An interview wit	th Direct Support			information/description was no	ot	
		(DSP) was conducted on			an accurate descriptor. (See		
		A.M DSP #1 indicated			W104, 122, and 192 for ensurance to compliance)		
					Nursing care is available 24 ho	nure	
		he hospital but was not			per day, including weekends a		
	aware why.				holidays. A Nurse is on-call a		
					available to the facility via		
		nt A's record was			telephone and if necessary,		
	conducted on 10	/17/12 at 11:25 A.M			physically in the home to		
	Review of client	A's medical record			evaluate/assess an issue.		
	indicated:						
	Nursing notation	dated 10/15/12: "I					
	_						
	•	e call from group home on					
		P.M., DSP stated she					
		mer woke up this					
	morning with blo	ood on her pillowcase and					
	that her right ear	had a scratch on it and					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G464		LDING	NSTRUCTION 00	(X3) DATE COMPI 10/26	
	PROVIDER OR SUPPLIER		p. wii.	STREET A	DDRESS, CITY, STATE, ZIP CODE DODLANE LVILLE, IN 46410	•	
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	ON BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPRODEFICIENCY)	PRIATE	DATE
	_	had stop (sic). Staff					
	` ′	ear and applied triple ent. I ask (sic) staff					
		h was. I was told it was					
	across the top of	her ear not up and down					
		r. I ask (sic) staff at this					
		I the ear apart if you used					
	_	ds again is it a scratch or of her ear. Staff told me					
	_	an not be pulled apart. I					
		t looked like it could be					
		taff told me no that it was					
	` ′	rmed staff that they have					
	already did (sic)	first aid care and to apply					
	an ice pack for 2	0 minutes to the swollen					
	•	Call me or [Nurse #2]					
		orsens or any other					
	•	this problem." No					
		tation was noted in client					
		rd to indicate the					
		staff physically assessed injury on 10/14/12.					
	chefit A's noted	injury on 10/14/12.					
	A review of inve	estigation record #18218					
	and #18189 date	•					
	conducted on 10	/19/12 at 2:35 P.M					
	Review of the re	cord indicated the					
	following:						
	Incident report d	ated 10/14/12: "[Client					
	•	dried blood on her arm					
		n't know where blood					
	•	I (DSP #13) examined					
	her body and dis	covered there was blood					

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Event ID: D4VZ11

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i f			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G464	B. WIN	_		10/26/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ADC 05	NODTHWEST IND	IANIA INIC. THE			OODLANE		
	NORTHWEST INDI				LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·		IAG			DATE
		nd was coming from her ected area and put					
		•					
		nd ice. Checked through					
	_	ich person (s) was this treferred to?Nurse, by					
		• •					
	•	otified: [Residential nagement Director name],					
	_	P.M., [Behavior Health					
		12, 2:00 P.M Part B					
		Service Coordinator					
		11:30 A.M" The report					
		•					
		the facility's administrator					
	· ·	notified of client A's					
	injury of unknov	vn origin.					
	Bureau of Devel	opmental Disabilities					
) report dated 10/14/12					
	,	eived a call at 1:35 P.M.					
	on 10/14/12 fron	n [client A's guardian]					
	`						
	noticed she was	bleeding. They (client					
		SP #13) traced the blood					
		there is approximately a					
		t. At this time, it is					
		· ·					
		om] for evaluation of the					
		s in the hospital at this					
		•					
		her ear at noon tomorrow					
	10/16/12An in	vestigation into the cause					
		n initiated and staff has					
	on 10/14/12 from (Service Coordin niece had come to noticed she was A's niece and DS to her ear where 1 inch curved cu unclear how the Coordinator visit directed staff to (Emergency Roo cut. She remains time and is set for blood clot from 1 10/16/12An in	n [client A's guardian] nator). She stated that her to pick [client A] up and bleeding. They (client SP #13) traced the blood there is approximately a t. At this time, it is injury occurredService ted the group home and take [client A] to the ER om] for evaluation of the s in the hospital at this or surgery to remove a ther ear at noon tomorrow evestigation into the cause					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G464		LDING	NSTRUCTION 00	(X3) DATE COMPI 10/26	
	PROVIDER OR SUPPLIER		P . W.	STREET A 2414 W	DDRESS, CITY, STATE, ZIP CODE OODLANE LVILLE, IN 46410	•	
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Inded at this time."		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	"Date 10/15/12 investigation: [O A's niece] stated aunt's (client A) on Sunday to tak When she entere was sitting in a c trying to tie her s went over to assi shoe and noticed A]'s pink shirt. middle of her for upper arm (near that at first becan maybe it was che been there to vis she has had food closer look she t blood. [Client A #13] if she knew [DSP #13] put of that it looked lik niece] lifted her blood had come anything. She to should take her i both took her shi #13] stated she v the bedroom/on niece] then stated coming from, fro	Phone Interview for Client A's niece]: "[Client that she went to her home around 12:15 P.M. the her some snack foods. It that the two the home, [client A] thair in the t.v. room shoe. [Client A's niece] that [client A] with the land a dark stain on [client I'he stain went from the trearm to the middle of her the muscle). She stated use it was dark brown that occolate, since she has it [client A] before and all over her. Taking a then thought it might be the land the stain was and in her gloves and stated the blood. [Client A's shirt to see where the from and did not see old [DSP #13] that they not the bathroom. They was going to go look in the bed. [Client A's del I know where it is on the ear.'Blood in came back with the					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G464	LDING	NSTRUCTION 00	(X3) DATE COMPL 10/26/	ETED
	PROVIDER OR SUPPLIER		2414 W	ADDRESS, CITY, STATE, ZIP CODE OODLANE LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	blood on the case grabbed both the took them some took [client A] to clean shirt. [Clie blood on the pill through the pillo took the picture. [client A's niece] to the chair in the #13] put ointmer niece] stated that and responded be She asked [DSP going to see her. that no one woul Sunday, but she they will look at [client A's niece] see if she could be out of the bed. Out of the bed. Out of the bed. Othat could have could have could have considered and [DSP #13] stated she were p.M. the night be anything. [Client how had she not and [DSP #13] see [Client A's niece] aunt. She told he [client A] should Aunt called the have sunday and	stated that there was e. [DSP #13] then e shirt and pillow case and where. [Client A's niece] o her room to get her a ent A's niece] noticed ow that had soaked w case. This is when she Both [DSP #13] and walked [client A] back e t.v. room where [DSP ent on her ear. [Client A's et the stain was enormous lood was still coming out. #13] if someone was [DSP #13] responded d see her because it was will go to workshop and her. [DSP #13] and went to the bedroom to have hit something/fell Could not see anything eaused the injury. [DSP evas with her until 10:00 effore and had not noticed at A's niece] asked her noticed such a large stain tated I did not notice. el went outside to call her er aunt that she thought l be seen by a doctor. house and was told that it [client A] would be seen Aunt called [SC] and				

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	COMPI	
AND PLAN	OF CORRECTION	15G464		LDING	00	COMPL 10/26/	
		100404	B. WIN			10/20/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			OODLANE LLVILLE, IN 46410		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	nt A's niece] back to tell					
	her to go back in	to the house because					
	staff had told [So	C] that she had been					
	aware of the inju	ry. [SC] showed up at					
	the house and to	ld [DSP #13] to take her					
	to the emergency	room. [DSP #13]					
	responded oh I'm	the one who has to take					
	her. [SC] stated	I do not care who takes					
	her, but someone	e needs to. [DSP #13] got					
	off the van at the	hospital and walked					
	away from [clien	nt A] because it was					
	raining and she	lid not want to get wetit					
	was quite a dista	nce between [client A]					
	and [DSP #13].	[Client A's niece] had to					
		up the curb because					
		ed to walk up. While					
		it A] they asked when her					
	" " "	[client A's niece] did not					
	1	ed who her doctor was,					
	_	did not know and [DSP					
	"	s a long time since she					
	_	ne to the hospital 'I don't					
	· ·	ure and I did not bring					
	_	e.' [Client A's niece]					
		or the information. [DSP					
		extra underwear and					
		rself. Had to tape a					
		herI (investigator #1)					
		niece] back on 10/16/12					
	l -	P #14], the other staff. I					
	_	[DSP #14] was when she					
		use. [Client A's niece]					
		er [DSP #14] or her car					
		[Client A's niece] did					
	was at the house.	. [Chent A s mete] ulu					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G464	(X2) MULT A. BUILDI B. WING		00	(X3) DATE : COMPL 10/26/	ETED
	PROVIDER OR SUPPLIER		2	2414 WC	DDRESS, CITY, STATE, ZIP CODE DODLANE LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	phone and heard noticed any injurafter the call [DS door. [Client A's thought it was stat the house because that she has been weekend only [I There has (sic) in house." "Date 10/15/12 [Client A's sister A's sister], [client that [client A] we due to a blood of going through the were also going she may have a constant of the state of the	all [DSP #14] on the her ask if she had by to [client A]. Not long SP #14] walked in the strange that [DSP #13] was assessed that she range that [DSP #13] was assessed to see [client A] on the DSP #14] has been there, of been 2 staff at the seed of the ear. They were seed to the ear. They were seed to try to repair the ear and couple of stitches. Doctor at the injury was caused the head/ear." Main Center: [DSP seed with [client A] on 14, 2012. I noticed the mice arrived. It was pupper right ear. She with. It's normal for [client mile after getting up unless standed (sic) pop. When I up she said she wanted nospital. I can't remember then [SC] came she said it					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	15G464		LDING	00	10/26/	
		100404	B. WIN			10/20/	ZU 1Z
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	ANA INC, THE			OODLANE LLVILLE, IN 46410		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	_	to go to the hospital and					
	_	roceeded to go. When					
	_	took her in bathroom to					
	<u>-</u>	and discovered where the					
		ed the nurse first and she					
	_	clean with ointment and					
	_	get her to the doctor on					
		g. I noticed the blood on					
	•	when the niece discovered					
		The reason I put 10 A.M.					
		the time she came out of					
		st when I seen (sic) the					
		it was that bad to go to					
	_	when I seen (sic) it in the					
	-	etty bad. No abuse seen					
		s other client tries to get					
	to her which is n	ot often or when she hits					
	herselfWe prod	ceeded to the hospital.					
	We got in van to	go to hospital and sat in					
	ER room for bou	at (sic) 4 hours. We got					
	her registered. S	he finally went in the					
	back got the ear	cleaned up. The doctor					
	came in and said	he wanted to get a closer					
	look at it so he w	as going to numb her ear					
	and put her in a	room. He said that it					
	looked kinda (sid	e) old but he wasn't					
	sureI explained	l it to the nurse as a deep					
	scratch or cut on	the earWhen speaking					
	to whomever on	the phone, they were					
	demanding her to	o go to the hospital and I					
	said I had to call	the nurse and see what					
	she says and we	will go from there. She					
	was saying she s	aw the pictures and					
	wanted her to go	now but I had to follow					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G464	B. WIN			10/26/	2012
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
APC OF	NORTHWEST IND	IANA INC. THE			OODLANE LLVILLE, IN 46410		
			ı	<u> </u>	LEVILLE, IN 404 IO		710
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	proper procedure	eI (investigator #1)					
		SP #14] was during this					
	-	#13) stated that she was					
	· ·	he was in the basement. I					
	asked her which	one was she, out of the					
	house or in the b	pasement. She stated					
	probably out get	ting lunch, but was only					
	gone 30 minutes	sShe was out of the					
	house."						
	"Date 10/16/12	Main: [Area Manager]:					
	All group homes	s are double staffed at all					
	•	ring the night shift. Any					
		the group home during					
	their shift a clier	nt should be with them."					
		[Service Coordinator]: I					
		unday at 1:35 P.M. from					
	=	#2] stating that her niece					
	-	nt A] and noticed she had					
		er sleeve. She stated staff					
	=	iece] took [client A] into					
		do a body check. They					
	1	njury. [Client A's niece]					
	~	A]'s bedroom and					
		her pillow. She then					
	_	A]'s head finding blood in at on her right ear. I					
		home speaking to [DSP					
		ted her to write an					
	-	o which she said, 'I guess					
	_	huh?' I asked the					
		cut. [DSP #13] said she'd					
		e name] who directed her					
	spoken to [nuise	maniej who allected her					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G464	B. WIN	G		10/26/	2012
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ADO 05	NODEL WATER TO SE	IANIA INO TUE			OODLANE		
ARC OF	NORTHWEST IND	IANA INC, THE		MEKKII	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)				(X5)
PREFIX		CY MUST BE PRECEDED BY FULL			ATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DLI TELLACT)		DATE
		and apply antibiotic					
		t the wound looked much					
		ed blood but once it was					
		l better. I told her I was					
		en I arrived [client A]					
		r chair. I could see the					
		from entrance. I put on					
	-	ed at [client A]'s ear					
		out through her ear. It was					
	_	then told both staff,					
		to take her to the ER.' To					
	_	id 'So I guess it's gotta be					
		t too. If it's like that, its					
	•	' I said, 'It doesn't matter					
	-	omeone needs to grab the					
		er and take her. Her niece					
	1	While [DSP #13] got					
		to go, her niece and I					
		oom to talk. I noticed					
	_	on the bed. her niece					
		take pictures of the					
		but the first thing [DSP					
	_	ow them in the washer.'					
		nger (wire) on the bed. I					
		ck for blood but there					
		cked the room for sharp					
	_ ·	rs but found none. The					
		lt [DSP #13] had an					
		when [client A's sister					
		lient A] be taken to get					
	medical attention	n, that [DSP #13] said 'Oh					
	we ain't finna (si	c) do that, it's the					
	weekend.' When	I looked at the incident					
	report it was tim	ed for 10 A.M. as if staff					
	l .						<u> </u>

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G464	A. BUIL	DING	NSTRUCTION 00	(X3) DATE COMPI 10/26	ETED
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				OODLANE		
ARC OF	NORTHWEST IND	ANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		before niece arrived, but					
		e to be done at around 2					
		me there were no other					
		No one had attacked					
		ey had no idea what had					
		nt A's niece] stated her ith the bloody pillow.					
		[client A] was in different					
	clothes and pillo	=					
	cionics and pino	w was imssing.					
	"Date 10/16/12	.Investigator office					
		ceived a phone call from					
	-	0/14/12 at 1:28 P.M					
	1 ~ ^	hat she noted that					
	consumer woke	up this morning with					
		and pillowcase and that					
		bleeding from what what					
	looks like a scrat	sch. I ask (sic) staff to					
	tell me about this	s client (sic) she told me					
	that consumer w	ill hit herself a lot of					
	times. She then	told me that this					
	consumer's fami	ly member was at the					
	house and wante	d her to go to the					
	emergency room	. Staff told family that					
	she had to call th	e nurse. DSP told me					
		call [nurse #2] (this					
	· · · · · · · · · · · · · · · · · · ·	there was no answer. So					
		on the emergency. DSP					
		ne that it was a scratch on					
		ear and that she cleanse					
		e) applied triple antibiotic					
		bleeding had stop (sic).					
		DSP staff several times					
	about this matter	asking was it a scratch					

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	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G464	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/26/2012		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2414 WOODLANE MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION		
	or a laceration. DSP staff continued in saying it was a scratch on her ear. I ask (sic) what part of the ear (sic) she told me it was on top of the ear and that the scratch was not vertical but it was horizontal. I then ask (sic) this DSP staff if she could take both of her hands and pull the ear apart where the scratch was noted to be she replied no that it was just a scratch and that the ear was swollen. I informed her a scratch to the ear was not an emergency (sic) to apply an ice pack to the swollen part of the ear for 20 minutes. Staff told me that consumer will not let her hold ice to her ear. I told her to try and if the problem gets worse or any other complaints to please call me back or call her nurse [nurse #2]." "Date 10/16/12: Nurse office[Nurse #2]: I spoke with family of [client A] at approximately 1:00 P.M. on 10/16/12. She (the sister) stated that during surgery, they cleaned out infection in her ear. She stated that she received 7 stitches. I asked her if the doctor knew how the laceration occurred and she stated blunt force trauma." "Conclusion: Injury of unknown origin-Substantiated. Staff do not know how injuries occurred. Neglect: SubstantiatedNeglect, falsification of documentation, failure to follow agency					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
	15G464		B. WIN	G		10/26/2012	
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE		
					OODLANE		
ARC OF NORTHWEST INDIANA INC, THE				MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PECULATIONS OF LISC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG				PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION DATE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		+	IAU			DATE
	policy and procedureBoth [staff #13 and #14] terminated for neglect, Falsification of documentation, Failure to follow agency policy and procedure."						
	agency poncy an	id procedure.					
	A review of client A's hospital medical						
		ucted on 10/26/12 at 3:20					
		f the medical record					
	indicated:	Tille illedical feedia					
	marcatea.						
	Ear Nose Throat (ENT) physician notation dated 10/15/12: "Diagnosis: Laceration to right ear of undetermined duration and origin-hematoma of right ear, possible traumatic origin and bilateral cerum impactionEar: Right. There is right ear pain the almost healed laceration						
	which is horizon	tal in nature. There is a					
	hematoma under	meath this. The cartilage					
	of the ear seems	to be slightly distorted on					
	the right side. T	here is impacted					
	sediment in right	t ear canalLeft:					
	Sediment impact	tion no obvious trauma."					
	1	ysician (PCP) notation					
		"laceration: Right					
	· ·	n of neglectDrain					
		r laceration and remove					
	impacted cerume	en bilaterally."					
	An intomicor	th Licensed Practical					
	Nurse #1 (LPN) was conducted on 10/26/12 at 2:45 P.M When asked if she was contacted on 10/14/12 in regards to						
	was contacted of	1 10/14/12 III legalus to					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		IDENTIFICATION NUMBER:		LDING	00	1		
15G464		B. WING			10/26/	ZU 1Z		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
ARC OF NORTHWEST INDIANA INC, THE			2414 WOODLANE MERRILLVILLE, IN 46410					
(X4) ID		<u> </u>		ID	,		(V5)	
PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	client A's injury, LPN #2 stated "Yes, the staff said they attempted to contact the group home assigned nurse, but she did							
	not answer her phone, so the staff called							
	the on-call phone and reached me."							
	•	ne injury was considered						
	an injury of unknown origin, the LPN							
	stated "Yes." When asked if nursing staff							
		uries of unknown origin,						
		I don't know what the						
	policy is on that.	" When asked if she or						
	any facility nurse went to the group home							
	and physically assessed client A's injury							
	of unknown orig	in, the LPN stated, "No, I						
	_	check it on Monday						
		it was a scratch." When						
	asked if she dire	cted DSP #13 not to take						
	client A to the en	nergency room after the						
		requested she be taken,						
	-	Yes, I told her to do first						
	aid care and not	·						
	emergency room	because it was a scratch,						
	and scratches do not require emergency care."							
	An interview wit	th LPN #2 was conducted						
	on 10/26/12 at 4	:15 P.M When LPN #2,						
	who is the assign	ned group home nurse,						
	was asked what	client A's Physician noted						
		nown origin as being						
		e stated "Blunt force						
	trauma."							
	An interview wit	th the Service						

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	of correction identification number: 15G464	(X2) MULTIPLE CON A. BUILDING B. WING	00	COMPLETED 10/26/2012			
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 2414 WOODLANE MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE		
	Coordinator (SC) was conducted on 10/26/12 at 4:00 P.M The SC indicated there should have been two staff at the group home on 10/14/12. The SC indicated nursing staff should have gone to the group home to physically assess client A's injury and further indicated client A should have been taken to the emergency room when the guardian requested client A be transported for medical attention. When asked if she went to the hospital with client A, the SC stated "No." No documentation was available for review to indicate nursing staff assessed/treated client A's injury of unknown injury. This federal tag relates to complaint #IN00118284.						

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